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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAILED JUN 5 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

19506

State File No. ~~19200~~

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 139

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Calvertonia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City of Boone State Cancer Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community by days
years, months or days)

3. (a) PRINT FULL NAME Annie Grabosch

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single/widowed, married, divorced Married
6. (b) Name of husband or wife William Grabosch 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased May 19 1875
(Month) (Day) (Year)

8. AGE: Years 67 Months 11 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Sullivan Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER-FATHER { 12. Name Wash Pierson
13. Birthplace unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Hettie Hill
15. Birthplace unknown 6
(City, town, or county) (State or foreign country)

16. (a) Informant Social Service Board
(b) Address Above Hospital

17. (a) Burial (b) Date thereof May 17, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Palock Cem.

18. (a) Signature of funeral director Alvin J. Foutner
(b) Address Green City, Mo.

19. (a) 5/23/41 (b) Albee Selby
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Llivan ¹⁰⁵
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R#2 Green City, Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1941 hour 3 minute 20 A.M.

21. I hereby certify that I attended the deceased from 5-12, 1941, to 5-18, 1941
that I last saw her alive on 5-18, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
1) Acute Cardiac Decompensation
(Post-operative)
Due to (2) Carcinoma of Lt Breast
with Billary Metastasis
Due to (3) Early pneumonia bronchial
(4) mild Hypertensive cardiac
vascular disease
Other conditions _____
(Include pregnancy within 3 months of death)

Duration

Major findings:
Of operations _____ SD
Of autopsy See above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature James J. Ackerman (M. D. or other) ^{11 M. 17}
Address E. 112 E. 1st St. State Cancer Hospital Date signed 5/18/41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.